**NH MEDICAL CONTROL BOARD**

**Richard M. Flynn Fire Academy**
**222 Sheep Davis Road**
**Concord, NH**

**MINUTES OF MEETING**

**November 19, 2005**

**Members Present:** Donavon Albertson, MD; Chris Fore, MD; Frank Hubbell, DO; Jim Martin, MD; Douglas McVicar, MD; Sue Prentiss, Bureau Chief; John Sutton, MD; Tom D'Aprix, MD; Norman Yanofsky, MD

**Members Absent:** Jeff Johnson, MD; Patrick Lanzetta, MD; Joseph Mastromarino, MD; Joseph Sabato, MD; William Siegart, DO;

**Guests:** Rep Steve L'Heureux, William Thorpe, Jr; Dave Dubey; Christopher Dubey; Michael Pepin; Doug Martin; Jeff Stone; Ed Laverty; Allan Bryant; Randy Flynn; Harry Brown; Janet Houston; Linda Powell; Steve Erickson; Jeanne Erickson; Wes Russell; Fran Dupuis

**Bureau Staff:** Liza Burrill, Education Coordinator; Kathy Doolan, Field Services Coordinator; Vicki Blanchard, ALS Coordinator; Fred von Recklinghausen, Research Coordinator.

## I. CALL TO ORDER

**Item 1.** The meeting of the NH Medical Control Board (MCB) was called to order by McVicar on November 17, 2005 at the Richard M. Flynn Fire Academy in Concord, NH.

## II. ACCEPTANCE OF MINUTES

**Item 1.** September 15, 2006 Minutes were previously approved via email.

## III. DISCUSSION AND ACTION PROJECTS

**Item 1. E-911 Update Rep Steve L'Heureux**

L'Heureux reported that the E-911 system is "conditionally" re-accredited. All 20 points needed for re-accreditation were met, and as soon as a technicality is cleared up, he feels confident that full re-accreditation will be granted.

Personnel changes at the Bureau of Emergency Communication included the recent hire of Bill Kinch. Bill is world-renowned for having written the Priority Medical Dispatch system. Bill replaces Bobby Silvestriadis. Additionally, a

fulltime staff member for EMD quality assurance has been hired, allowing the bureau to continually perform dispatch review.

L'Heureux also reported that E-911 is currently receiving approximately 50% of its calls from cell phones.

At the request of the chairman, L'Heureux also gave a brief preview of the upcoming Legislative season. At this time 700 bills have been filed, a very large number for the second year of a legislative biennium. Right now only the titles of the LSRs are posted. Within the next few weeks and into early January the bills themselves will be filed and available on Webster. Then we'll know for sure what is pending in the EMS and public safety areas. Rep L'Heureux is co-sponsoring a bill establishing a committee to study the funding necessary to operate local hazardous materials programs in New Hampshire. Other than that, he is not aware of much pending that affects EMS.

Finally, L'Heureux said how much he appreciated the Medical Control Board's thank-you letter for his support and work on HB257. He stated while it was one of the toughest bills he ever faced, it also taught him a lot.

**Item 2. RSI/Prerequisites - Don Albertson, MD**

At this time we have identified four prehospital RSI programs in the State of New Hampshire: DHART, Frisbee Hospital, Concord Fire and Derry Fire. Data recently collected from these groups showed very high success rates in the RSI procedure. What the data did not reveal was the prerequisite experience needed for a paramedic to enter an RSI program in order to assure quality. Albertson reported that there was unsettled literature at this time with no proven standards for adoption. A straw poll was conducted earlier this week. The votes broke down as follows: 4 votes for 10 successful intubations in the twelve months prior to RSI training, 2 votes for 5 intubations, and 1 vote that a specific number should not be part of the prerequisites. In Massachusetts, 20 tubes in twelve months is used by some programs.

In view of this information Albertson proposed the Board vote to approve 10 live tubes within the past year as above, with 5 tubes needed for re-certification, and that RSI not be performed unless two (2) paramedics are present with the patient. Albertson stated this would be a safe measure and could be reviewed and changed in the future if necessary.

Following Albertson's suggestion there was a discussion regarding intubation frequencies currently in New Hampshire, the differences between the existing programs, realistic assessment of available resources, as well as an emphasis on education and defining quality assurance parameters. Several of the board members had concern with the specific requirement of 10 intubations and how it would effect those programs already doing the procedure. McVicar pointed out that in no way did the Board want to kill any current programs that are performing well.

Fred Von Recklinghausen reported that in TEMSIS as of 16 November (with only 1/3rd of squads filing reports so far) since July there were 81 intubations, of which 15 were RSI patients.

Thorough discussion continued with focus on what indicates mastery. Are numbers alone enough? What about success rate? Mentoring? Supervision?

Because the limits proposed by Albertson and the committee could be quite difficult if not impossible for some of the 4 existing programs, the MCB decided on Chief Prentiss's suggestion to create a prerequisite which grandfathers the current RSI programs (i.e. Concord Fire, Derry Fire, DHART and Frisbee Hospital and any others that are now ongoing and which meet the same standards as those four) and to require all operating RSI programs to report a standard set of data for evaluation. Von Recklinghausen is to work with these programs to develop the standard data set, and will report periodically to the MCB.

No new programs will be allowed until more specific and generalizable criteria are developed, which should take no more than a year. Doug Martin, Frisbee Hospital's EMS Coordinator, agreed to poll the NH EMS Coordinators to find out if there were any other services currently involved in an RSI program. D'Aprix reported that he recently was informed that Goffstown had an RSI program, but no other information.

Finally, a statement of intent will go out to all the hospitals prior to January 1, 2006 to ensure that all know no new RSI programs are allowed until the quantitative and qualitative issues are settled and final prerequisites are issued.

Motion: That the prerequisite will grandfather the four programs (plus others that are now ongoing that meet the same standards as those four) but not allow any new programs until we have sufficient information to establish more permanent prerequisites, and that we require systematic reporting of data on a standard format that the active programs will develop in conjunction with Von Recklinghausen.

VOTE: PASSED Yes - 7, No - 1

**Item 3 HB257 Implementation - Sue Prentiss**

Prentiss reported that with the passing of HB257, rules changes were needed. At this time a draft document has been completed and will be presented to the Coordinating Board this afternoon. Prentiss outlined the changes that need to occur in rule to comply with HB257. They include:

- Removal of "local option" language
- Creating a home for non-DOT skills and curriculum, with educational standards and verification.
- ALS equipment and verification

- Licensing changes to include transition program verification, protocol exam and changes in the actual form.
- I/C Education on the transition programs and changes in the form for establishing courses.
- Prerequisites, process and forms
- Redefining the responsibilities of the medical directors and unit leaders
- Quality Management components
- Security from discovery of quality management privileged information
- A rule adopting a specific edition of the Protocols by reference (after which the MCB cannot change the protocols without changing the rule).

**Item 4. First Responder Scope of Practice - Harry Brown, Linda Powell and Sue Prentiss**

McVicar introduced this agenda item by pointing out that the scope of practice of the first responder was not under the authority of the Medical Control Board, but rather a function of the Coordinating Board. However, since the Medical Control Board is responsible for creating and approving protocols, and since Chief Prentiss wanted to have the two boards working in harmony, this issue finds itself on the MCB agenda today.

Prentiss then presented a informational PowerPoint, which included with the following history:

- In 1997 the former Bureau Chief, Martin Singer sent a memo out advising that the First Responder could perform skills above and beyond the 1995 First Responder DOT curriculum under local option.
- In 2003 the Bureau again sent out a memo mirroring the 1997 statement, that additional skills were to be performed under local option.
- In October 2005 the Bureau was approached with concerns regarding the change in status from local option to statewide protocols and the impact it would have on the services utilizing first responders. Specifically, the statewide protocols did not allow the first responders to operate above the DOT curriculum.

The Bureau responded by sending out a survey to all the services with first responders. 48% of the services responded to the survey. From the results, it was learned that approximately 80% - 95% of the first responders were performing skills above and beyond the DOT curriculum. These skills are spinal immobilization, vital signs, oxygen administration and splinting.

Prentiss suggested a proposal to waive the current first responders for a period of time while a committee is formed to investigate options and develop a plan, including a possible transition program.

Next Harry Brown, who is a provider in both Walpole and Colebrook, presented to the Board his concerns for the first responder level of care. He began by stating that he felt the North Country was in an EMS crisis. His concern was that on January 1, 2006, when the NH Patient Care Protocols went statewide the first responders would lose their enhanced skills.

Brown provided a comprehensive PowerPoint program including a summary of training currently given to the first responders, specifically the four modules noted above: spinal immobilization, vital signs, oxygen administration and splinting. Brown referred to those first responders with these additional skills as "enhanced first responders."

Brown's presentation continued with statistics of first responders in the North Country, their vial role in responses to snowmobile accidents, and the frequent need for their enhanced skills when other providers are not available. Additionally, Brown outlined the additional modules that he felt would be necessary for enahanced first responder to bridge to the EMT-Basic level.

Finally Brown presented the board with the following suggestion:

1. Provide a waiver through December 31, 2006 for the "enhanced first responders"
2. Create a bridge from First Responder to EMT-Basic
3. Preserve the option for those first responders who did not want to bridge to EMT-Basics to drop back to the DOT FR level of skills

Linda Powell, NREMT-Basic from Bradford Rescue, then presented her concerns to the Board. Powell explained that Bradford was increasingly having difficulty in recruiting and retaining volunteers. Utilizing first responders with enhanced psychomotor skills makes a practical option for people to volunteer for their community without a huge time commitment to training and continuing education.

Powell presented a handout (see attached) which addressed the First Responder curriculum and the DOT statements that the curriculum is not intended for those wishing to work on an ambulance. Powell's document also supported the need for the 4 additional modules. Powell suggested a change in the preface of the protocols to allow the first responders to perform "at the level of their training."

Prentiss reminded the group of how waivers work. If a waiver were to be created for "enhanced First Responders", it would be the responsibility of the EMS unit to file a request for such a waiver, and provide proof of the training and a description of the training.

At the conclusion of the discussion, the Medical Control Board made the following recommendation to the Coordinating Board:

McVicar moved and Sutton 2nd the following recommendation to the Coordinating Board:

1. Endorse an “enhanced first responder” with the additional skills of spinal immobilization, vital signs, oxygen administration, and splinting.
2. To prevent interruption in patient care, provide a waiver for those currently trained in the enhanced skills.
3. Endorse and develop a bridge course to EMT-Basic.
4. Create standardized education and evaluation of these enhanced skills with a transition program.

VOTE: PASSED Yes - 5, No - 0, Abstain - 2.

## IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

**Item 1. ACEP-Doug McVicar, MD**

McVicar reported that he had been in contact with ACEP President Sarah Johansen to set up a joint meeting. The following dates are available: December 6, 14 or 15. McVicar hopes the Agenda will include Statewide Protocols with the elimination of local option. Then there should be a significant period to gather the thoughts of EMS Physicians on the desired direction of protocols and the development of the NH EMS system.

**Item 2. Bureau and Division Updates - Sue Prentiss**

Prentiss referred to the report included in the meeting's packet, anyone with questions, comments, or concerns were encouraged to contact her.

**Item 3. Intersections Project: - Joe Sabato, MD - No report**

**Item 4. NH Trauma System - John Sutton, MD**

Sutton reported that on November 30, 2005, the 5th annual NH Trauma Conference will be held in Meredith. This year there will be emphasis on Trauma Teams.

Additionally, Sutton reported the re-verification process for hospital trauma designation continues, with a formal review at the Febuary 2006 meeting. Also, Cottage Hospital is currently going through the process for the first time.

**Item 5. TEMSIS - Fred von Recklinghausen**

Von Recklinghausen reported that currently there were 10,000 calls in the system, with approximately 1/3rd of the services reporting. Blood glucose analysis and venous access are the most common invasive procedures. Patient gender continues to be approximately 50/50.

Region II had just begun its training on TEMSIS. Region II is the final region to train.

TEMSIS and CPR: It was explained to the board that with the provider database now established within TEMSIS, if a provider's CPR card expires, the system will automatically disable their ability to access TEMSIS. Reminder letters are being

sent out to providers 30 days in advance of their CPR expiration. These expiration reminder letters also contain a message explaining they will no longer be able to access TEMSIS in the event the CPR is not renewed and a copy of the new card is not forwarded to Tammy Fortier.

Albertson inquired what other states we were able to share data with. Von Recklinghausen replied that at this time we were in a consortium with seven other states -- Maine, Georgia, and some Midwestern states including Minnesota, Wisconsin and Missouri – and of these Maine data has the most compatibility and so Maine will be the most straightforward data sharing partner.

**Other Business: Adult Airway Adjuncts - Vicki Blanchard**

Blanchard requested that the board vote, for the record, which adult airway adjuncts could be used by which level of providers. Blanchard presented the board with a matrix, which she gleaned from minutes of past MCB meetings, of airway adjuncts matched to provider levels. (see attached). Tom D'Aprix moved to accept the assignment of airway modalities to licensure levels and training modules, as illustrated in the matrix. John Sutton 2nd. Unanimous vote to approve.

## V. ADJOURNMENT

**Motion** was made by McVicar and seconded by Sutton to adjourn.
Unanimous agreement adjourned at 12:15 PM.

## VI. NEXT MEETING

January 19, 2006 at the Richard M. Flynn Fire Academy, 222 Sheep Davis Road, Concord, NH.

Respectfully Submitted,

Suzanne M. Prentiss, Bureau Chief, EMS

(Prepared by Vicki Blanchard)

Under the advanced airway protocol, in the 2005 NH Patient Care Protocol, the specific level of licensure necessary to perform the insertion of the various adult airway adjuncts is not addressed. I purpose a vote from the Medical Control Board to approve the following adjuncts at these recommended levels of training and licensure. This will eliminate confusion in the EMS community on January 1, 2006, when the protocols go statewide.

| **ADULT AIRWAYS** | **LEVELS** | | |
|---|---|---|---|
| Combitube | Basic* | Intermediate* | Paramedic* |
| KING LT-D | Basic* | Intermediate* | Paramedic* |
| LMA | | Intermediate* | Paramedic* |
| ETT oral | | Intermediate▲ | Paramedic |
| ETT nasal | | | Paramedic |
| CPAP | | | Paramedic* |
| Cricothyrotomy | | | Paramedic* |
| RSI | | | Paramedic▲ |

*=Transition Program required prior to use.

▲=Prerequisite and training required prior to use.

FYI, the following is an extraction from the May 2004 Medical Control Board Meeting minutes:

"…The Board reviewed and discussed each of the following alternative airways and voted on what level of provider each should be approved for:

- **Esophageal Obturator Airway (EOA) and Esophageal Gastric Tube Airway (EGTA)** – voted unanimous to remove from all levels of provider.
- **Pharyngeal –Tracheal Lumen Airway (PtL)** – voted unanimous to remove from all levels of provider.
- **Esophageal Tracheal Combitube Airway** – voted unanimous to approve for Basic, Intermediates and Paramedics.
- **Laryngeal Mask Airway –** voted unanimous to approve for Intermediates and Paramedics for use with patients over 50 kilograms. This would include all variations of the LMA including the Fasttrack, etc.
- **Endotracheal Tube** – voted unanimous to approve for Intermediates for adult patients and for Paramedics for adult and pediatric patients.
- **Surgical Airways** – was tabled for a future meeting due to time.